Topic 10: *Pain/Palliation of Older Adults*

Competencies

1. Identify the incidence of pain in older adults.
2. Assess pain using client self-report and/or a validated pain instrument.
3. Discuss barriers to pain relief in the elderly.
4. Identify problems and strategies in assessing pain in cognitively impaired older adults.
5. Describe adverse consequences associated with pain in older adults.
6. Identify strategies and considerations in treating pain in older adults.
7. Discuss specific treatment strategies for pain management in older adults.
8. Plan care for assessing and managing pain in an older adult, including traditional and alternative pain treatment strategies.
9. Understand the definition and dimensions of palliative care.
10. Identify the dimensions of human experience impacting quality of life.
11. Describe assessment parameters important in palliative care.
12. Describe the nurse's role in supporting a multidisciplinary team approach to palliative and end-of-life care and identify the rationale for the team approach to care management.

Topic 10: *Pain/Palliation of Older Adults*

Content Outline

1. **Identify the incidence of pain in older adults.**
   - Pain is defined as an unpleasant sensory and/or emotional (suffering) experience. Chronic pain is defined as persistent pain that is not amenable to routine pain controls.
   - There is a threefold increase of persistent pain between 18 and 80 years of age.
   - The prevalence of pain of recent origin decreases with increased age. The prevalence of chronic pain increases with increased age. The prevalence of pain in those over age 60 years is double that of those below age 60 years.
   - An estimated 25% to 50% of community-dwelling older people suffer significant pain problems; an estimated 45% to 80% of nursing-home residents have substantial pain that is undertreated.
   - Osteoarthritis is the most common disorder associated with pain in older adults.
   - Pain associated with degenerative musculoskeletal processes and the cardiovascular system increases with age. Fractures of the spine, ribs, pelvis, and humerus increase with age.
   - Chronic pain is common in older people. They are likely to suffer from arthritis, bone and joint disorders, back problems, and many other chronic conditions, including neuropathic pain, post-stroke central or neuropathic pain, post-herpetic neuralgia, and post-amputation (phantom limb) pain.
   - Chronic pain may have serious adverse consequences among older adults.

- The frequency of undertreated pain in the elderly is unknown. However, there is a correlation between undermedication for pain and advanced age even though there is frequent overmedication of the older patient for other purposes.

2. Assess pain using client self-report and/or a validated pain instrument.

- The most accurate evidence of pain and its intensity is based on the client's description and self-report.
- Older adults may be reluctant to report pain, either because they expect pain with aging and become used to it, or because they prefer to describe discomfort, burning, or aching rather than use the term *pain.* Culture and gender influence how older adults react to pain.
- Characteristics that should be assessed include intensity, quality, onset, duration, client's manner of expressing pain, aggravating factors, and factors/conditions that relieve or minimize pain.
- Facial expressions and physical indicators don't always change when a client has chronic, persistent pain.
- Pain instruments may assist in quantification of pain (visual analog scale, word descriptor scale, numerical scale).
- Older adults unable to complete pain instruments may evidence pain by vocalizations and disruptive behaviors.

3. Discuss barriers to pain relief in the elderly.

- Belief that, compared to younger persons, older patients experience less pain.

- A variety of terms synonymous with pain should be used to screen older persons (i.e., burning, discomfort, aching, soreness, heaviness, tightness).
- Belief that older patients cannot tolerate opioids.
- Failure to apply standardized assessment instruments.
- Belief that the cognitively impaired elderly cannot be assessed for pain.
- Misinterpretation of cognitively impaired person's behavior as unrelated to pain.

4. Identify problems and strategies in assessing pain in cognitively impaired older adults.

- Cognitive impairments are not associated with decreased experience of pain but may be associated with decreased ability to report pain.
- Cognitively impaired older adults may not be able to adequately identify or communicate pain to caregivers.
- For older adults with cognitive or language impairments, recent changes in function and vocalizations (i.e., changes in gait, withdrawn or agitated behavior, moaning, groaning, appetite, sleep, or crying) should be evaluated as nonverbal pain behavior.
- Objective pain assessment instruments may be used with cognitively impaired older adults.
  —Adjustments are needed to assist elderly to report pain. The most appropriate scale should be used to accommodate for sensory losses, fatigue, slower processing, and timing in relation to activity.
  —Pain assessments are most accurate with present pain rather than recalled pain in older adults with cognitive impairment.

—Use of analgesics as an assessment tool for pain related behaviors in the cognitively impaired (i.e., assess for changes in behavior with use of analgesia).

- Reports from caregivers are valuable in assessing pain in cognitively impaired older adults.

5. Describe adverse consequences associated with pain in older adults.

- Adverse consequences of chronic pain include greatly decreased quality of life, depression, decreased socialization, sleep disturbance, impaired ambulation, suicidal ideation, decreased appetite and food intake, and increased health care utilization and costs.
- Older adults with pain should be assessed for depression.
- Chronic pain is associated with worsened gait disturbances, slower rehabilitation, and adverse effects of multiple drug prescriptions.
- Impact of uncontrolled pain may be evidenced in hopelessness and suffering.
- Depressed older adults may be more reluctant to report pain because they lack the hope that anything can be done.
- Nonverbal cues such as changes in function and behavior often indicate pain in depressed older adults or those with dementia. Pain may have adverse effects on other systems (mobility, sleep, nutrition, bowel and bladder, cognition).
- The presence of coexisting physical, psychological, spiritual, and cultural factors may impact adversely on pain management (these conditions include past experiences with pain, and treatment successes and failures).

Content Outline

6. **Identify strategies and considerations in treating pain in older adults.***
   - Every older adult presenting to a health-care agency should be assessed for evidence of chronic pain.
   - Any persistent or recurrent pain should be recognized as a significant problem.
   - Conditions that require specific interventions should be identified and treated definitively if possible (i.e., underlying diseases, debilitating psychiatric conditions, substance abuse).
   - Persons with chronic pain and/or their caregivers should be instructed to maintain a pain log or diary. It should include time, pain site(s), intensity, medications taken, relief obtained, side effects (if any), other pain-relief strategies, activity, and mood.
   - Persons with chronic pain should be reassessed regularly for improvement, deterioration, or complications related to treatment.

7. **Discuss specific treatment strategies for pain management in older adults.**

   Pharmacologic

   - Pharmacologic therapy is most effective when combined with nonpharmacologic strategies for managing pain.
   - The least invasive route of administering medication should be attempted first. Dosing requires careful titration, frequent assessment, and adjustments to

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* Chrischilles, Lemke, Wallace, and Drube, "Prevalence of Characteristics of Multiple Analgesic Drug Use in an Elderly Study Group" from the *Journal of American Geriatrics Society* 1990; 38(9): 979–984. Reprinted by permission of Blackwell Science, Inc.

optimize pain relief while monitoring and managing side effects.
- A bowel regime, with laxatives and stool softeners should be started proactively when opioids are begun.
- Fast-onset, short-acting analgesic medications are the drugs of choice for short-term, self-limiting pain.
- Acetaminophen is the medication of choice for relieving mild-to-moderate musculoskeletal pain.
- Chronic use of nonsteroidal anti-inflammatory drugs (NSAIDS) should be monitored cautiously in older adults. NSAIDS should not be used when abnormal renal function, peptic ulcer disease, or bleeding diathesis is present.
- Opioid analgesic medications may be helpful for episodic or chronic pain.
- Side effects of medication usage may be minimized with appropriate medications to prevent constipation, gastric distress, sedation, and nausea.

Nonpharmacologic

Nonpharmacologic strategies may be effective alone but are often combined with pharmacologic treatment. Most frequently used are:

- Education programs
- Cognitive programs aimed at modifying the global experience of pain and distress through imagery, relaxation, biofeedback, and hypnosis. The major goal is enhancing the older person's personal control.
- Behavioral programs discourage abnormal, unpredictable, or self-defeating behavior, and provide positive reinforcement for successes in achieving goals.

- Exercise programs
- Acupuncture
- Transcutaneous nerve stimulation (TCNS)
- Distractions to change focus away from pain
- Physical methods (heat, cold, massage) most useful in older adults with some cognitive impairment.
- Chiropractic
- Heat, cold, massage, relaxation
- Alternative/Complementary therapies
- Homeopathic
- Naturopathic
- Spiritual healing

8. Plan care for assessing and managing pain in an older adult, combining traditional and alternative pain treatment strategies.*

- Determine appropriate management based on the individual nursing diagnosis: alteration in comfort.
- Determine the tolerable level of pain, activity, and sedation, and set very specific patient-centered goals for pain management.
- Develop a plan to implement pharmacological and non-pharmacological strategies.
- Plan for an ongoing evaluation of pain that continuously utilizes client self-reports, validated pain instruments, and caregiver reports (as appropriate).
- In residential care facilities, teach nursing assistants how to assess and identify pain using a culturally appropriate scale.

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* American Geriatric Society Panel on Chronic Pain in Older Persons, "The Management of Chronic Pain in Older Persons" from the *Journal of American Geriatrics Society* 1998; 46(5): 635–651. Reprinted by permission of Blackwell Science, Inc.

Content Outline

9. Understand the definition and dimensions of palliative care.

The World Health Organization defines palliative care as the active total care of patients whose disease is not responsive to curative treatment. Control of pain, other symptoms, and psychological, social, and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of an illness in conjunction with curative treatment.*

- Enhance maximum comfort and function of the total patient. The goal of care is to provide physical, spiritual, psychological, and emotional support to promote well being at the end of life.
- Palliative care focuses on active communication between caregivers, families and patients to promote comfort and the reassurance that they will not be abandoned.
- Care for the patient and family requires the holistic intervention of a multidisciplinary team.
- Palliation is an integral part of the care continuum. Planning for care requires open communication between the multidisciplinary team members, the patient and the family. Care can begin with an emphasis on curative treatment, with only a small portion of palliative enhancement. Eventually when goals of care shift from

* McCaffery, M., and Pasero, C. (1999). *Pain: Clinical Manual* (2nd ed.). St. Louis, MO: Mosby Inc.; Doyle, D., Hanks, G., and MacDonald, N. (1998). *Oxford Textbook of Palliative Medicine.* New York: Oxford University Press.

curative to comfort, palliative care becomes the primary focus.

10. Identify the dimensions of human experience impacting quality of life.

Five dimensions of quality of life have been identified by Ira Byock and Melanie Merriman, authors of the Missoula-VITAS Quality of Life Index:*

- **Physical dimension:** physical distress; the experience of physical discomfort associated with progressive illness.
- **Function dimension:** the ability to perform functions and activities of daily living, related to one's expectations and adaptations to declining functionality.
- **Interpersonal dimension:** the degree of investment in personal relationships; the perceived quality of one's relations with family, friends, and others.
- **Well-being dimension:** how one feels within one's self; a sense of wellness, contentment or lack of contentment; a personal sense of well-being.
- **Transcendent dimension:** one's felt degree of connection with an enduring construct: may involve, but does not have to involve, one's sense of the meaning of life, suffering, death, afterlife, etc.

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* Byock, I., and Merriman, M. (1998). Measuring Quality of Life for Patients with Terminal Illness: The Missoula-VITAS Quality of Life Index. *Palliative Medicine, 12,* 231–244.

- As a person's physical and functional dimensions decline, increased attention to the interpersonal, well-being, and transcendent dimensions can enhance their quality of life.
- Terminal illness, as well as presenting the potential for physical distress and suffering, presents a final opportunity to complete tasks of life development. Quality of life is enhanced as tasks are completed.

11. Describe assessment parameters important in palliative care.

Data collection assesses all dimensions of a person and family as well as how changes in those dimensions affect the quality of life. Subjective and objective data collected from a palliative/comfort care perspective is based on what patients and families perceive as important to them at this time. Their identified goals become the focus and driving force for the care plan.

Assessment identifies specific issues and their etiology, including:

- Physical problems
- Psychosocial problems
- Spiritual problems
- Accomplishment of developmental tasks of life: completion and closure to the extent that the patient/family chooses to participate
- Family dynamics/relationship issues/opportunities
- Grief/loss/bereavement issues
- Functional status/environmental status

Content Outline

12. Describe the nurse's role in supporting a multidisciplinary team approach to palliative and end-of-life care and identify the rationale for the team approach to care management.

- The nurse identifies patient and family needs
- The nurse identifies and recruits members of the health care team that can make a contribution to palliative care of patient and family including:

  Physician

  Symptom management specialist

  Social worker

  Psychologist or counselor

  Pastoral care

  Physical therapy

  Occupational therapy

  Pharmacist

  Volunteers

  Family and significant others

- Many older adults have chronic coexisting problems and multiple pain needs.
- A multidisciplinary pain program can coordinate care by providing extensive and comprehensive management.
- Problems such as cognitive impairment, limited mobility, psychiatric disturbances, and social isolation can be appropriately managed by using a team approach.

Content Outline

- Team conferences provide the opportunity for the care providers to create an individualized treatment plan with and for the patient.
- The nurse promotes communication among the team and the setting of achievable goals based on the desires of the patient and family.
- The nurse identifies patient appropriateness for Hospice services and their availability.
- The patient and family should be encouraged to participate in goals of care, processes of care, and evaluation of the care program.

Instruments/Scales

GERIATRIC PAIN ASSESSMENT

Date:_____ Medical Record Number_____

Patient's Name_____

Problem List: Medications:

Pain Description:

Pattern: Constant Intermittant

Duration:_____

Location:_____

Character:

Lancinating Burning Stinging

Radiating Shooting Tingling

Pain Intensity:

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

Worst Pain in Last 24 hours:

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

Other Descriptors:

Mood:_____

Depression Screening Score: _____

Gait and Balance Score: _____

Exacerbating Factors:

Impaired Activities:

Relieving Factors:

Sleep Quality: _____

Bowel Habits: _____

Other Assessments or Comments: _____

Most Likely Cause of Pain:_____

Plans: _____

Figure 10.1 Example of a medical record form that can be used to summarize pain assessment in older persons. (*Source:* Clinical Practice Guidelines, May 1998, Vol. 46, No. 5, JAGS.)

Instruments/Scales

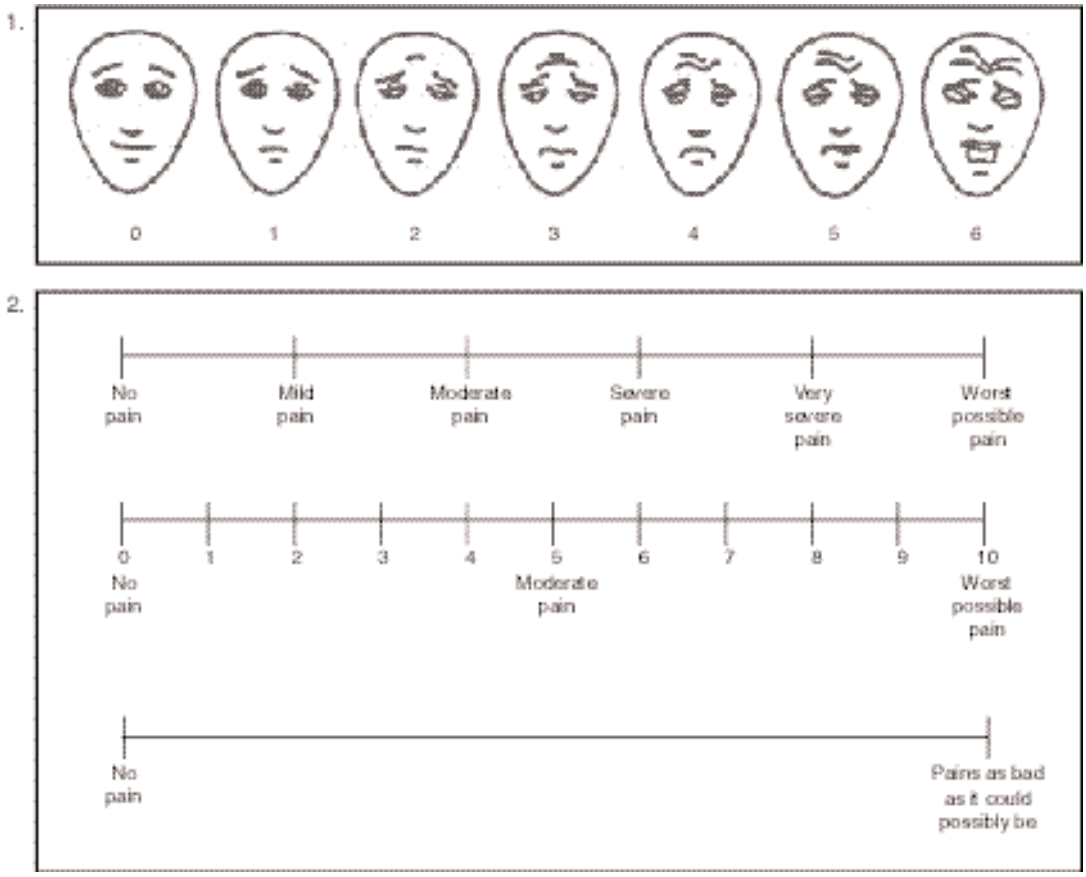

Figure 10.2 Examples of pain intensity scales for use with older patients. 1. A faces scale. Reprinted from *Pain* 1990;41(2):139–150, with kind permission of Elsevier Science–NL, Sara Burgerhartstraat 25, 1055 KV Amsterdam, The Netherlands. 2. Visual analogue scales.

Topic 10: *Pain/Palliation of Older Adults*

Case Study

Ms. R is an 87-year-old widow, residing independently in a continuing-care retirement community. She has a past medical history of lumbar stenosis, osteoarthritis, acquired spinal stenosis, diverticulosis with occasional flare-ups, esophageal strictures, and ETOH abuse. She lives alone, follows a diverticulitis diet, and is ambulatory and independent in activities of daily living (ADLs). Her weight is 123.5 pounds and has been stable over the past five years. She is alert and oriented and is continent of bowel and bladder but complains of frequent constipation. She takes a sleeping pill at night to help her fall asleep. Her closest relative is a sister-in-law who lives in a nearby state.

The patient presented to the ambulatory health clinic complaining of right-side sciatic pain. She was seen by the physician, who prescribed Darvocet N-100 every four hours for pain, physical therapy, ultrasound, and heat. She was then sent back to her apartment. She returned to the clinic the next day with increasing pain and decreasing ability to perform her ADLs. A bone scan revealed a sacral fracture. She was admitted to a nursing home, and bedrest, ultrasound, heat, and physical therapy were prescribed. Multiple pain treatments, including Tylox, Morphine Sulfate, Demerol, Morphine, Valium, and Flexeril, were prescribed and sequentially discontinued when found ineffective. In spite of the multiple pharmacological interventions, her pain persisted. A transelectrical nerve stimulation (TCNS) unit was tried, and her pain was eventually reduced to approximately three, on a scale of one to ten. Discharge was then planned.

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Topic 10: *Pain/Palliation of Older Adults*

Case Study

Mr. M is an 80-year-old man, with a past medical history of COPD and prostate cancer with metastasis to the bone. He was admitted to the hospital for episodes of dyspnea, anorexia, and increasing lethargy. His wife died of lung cancer six months ago and he was living alone and could no longer care for himself because of the progression of his COPD and his increasing lethargy and weight loss. He is alert and oriented but has frequent periods of confusion and agitation. While in the hospital he had rapidly declined, he was imminently dying and was becoming progressively anxious with increased episodes of shortness of breath despite all medical interventions. Attempted trials of morphine, steroids, bronchodilators, benzodiazapenes, and oxygen therapy were of minimal success.

Upon assessing this problem, the patient shared that he had a son whom he had not spoken to for 20 years. The patient was afraid of dying before mending that relationship, apologizing to the son, and letting him know he loved him. The hospice team assisted in locating his son and arranging for a visit. The patient and son were able to spend time together, give and receive forgiveness, and in so doing mend their relationship. The patient's unfinished relationship issues were the etiology of his physical episodes of shortness of breath.

Experiential Activities/ Clinical Experiences

1. **Role Play:** Using role playing or storytelling, verbalize your understanding of the pain experience in older adults. Discuss how you expect a person in pain to behave,
2. **Assess:** Choose a patient with a known painful condition and assess the client's pain using self-report and a validated pain assessment instrument. (Assessment may include assessment of mental/cognitive status and/or depression.)

   Gather additional information on the patient's spirituality and cultural preferences.
3. **Write Diagnosis:** Write a nursing diagnosis based on the client's history and on findings from the pain assessment.
4. **Review Records:** Review a client's clinical record and develop a plan of care using both pharmacological and nonpharmacological treatments.

   Review the side effects of each medication and incorporate appropriate interventions into the plan of care.

   Evaluate the effectiveness of the plan of care, using the pain assessment methods in the initial assessment.
5. **Interview:** Interview nursing assistants in residential facilities regarding their beliefs about pain in the elderly.
6. Interview nurses, patient family members, patients, yourself, or fellow students about any or all of the following:
   a. Attitudes and understanding of the components of palliative care.
   b. What constitutes a "good death."
   c. What psychological, social, and physical elements are needed to create the acceptance of impending death.

   Compare and contrast answers for each question.
7. Create a palliative care plan for a patient.

Topic 10: *Pain/Palliation of Older Adults*

Evaluation Strategies

1. Use any of the experiential activities as assignments for evaluation.
2. Test Questions: True or False

True The most accurate and reliable assessment of pain is the client's self-report.

True Cognitively impaired older adults may have more difficulty communicating pain than cognitively intact patients.

True Depression is associated with decreased reports of pain.

False NSAID medications are the treatment of choice in older adults.

True A plan of care for the older adult with pain should utilize the same pain assessment method for the initial assessment and subsequent evaluations of pain.

True Palliative measures can begin at time of diagnosis, enhancing care and improving quality of life for the patient facing a terminal illness.

False Assessment of the patients' pain should be focused primarily on the physical aspect of the experience.
(*Answer:* a comprehensive pain assessment should always evaluate not only the physical but the many other components of a patient's pain experience.)

False Palliative care is only appropriate for patients who are not seeking curative treatment.
(*Answer:* Palliative care can be given along a care continuum and during curative treatment. The focus will eventually shift towards palliative focused care towards end of life and curative therapy is no longer an option.)

Evaluation Strategies

False Palliative care plans are based on a medical diagnosis.
(*Answer:* Palliative care plans are based on physical, emotional, spiritual, and psychosocial components of the patient at the end of life.)

False The physician and the nurse should be the only care providers for the elderly patient.
(*Answer:* A multidisciplinary team consists of many different providers that all play an important role in a comprehensive care plan.)

Clinical evaluation may be measured through the development of a thorough plan of care for the older adult in pain, including the use of client self-report (i.e., pain log and diary), and/or a validated pain instrument for initial assessment and subsequent evaluations of pain; pain assessment with respect to cultural, spiritual, physical, and psychological disposition; goals based on the client's preference; appropriate nursing diagnoses; use of pharmacological and nonpharmacological strategies to minimize any adverse side effects of treatments.

Topic 10: *Pain/Palliation of Older Adults*

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